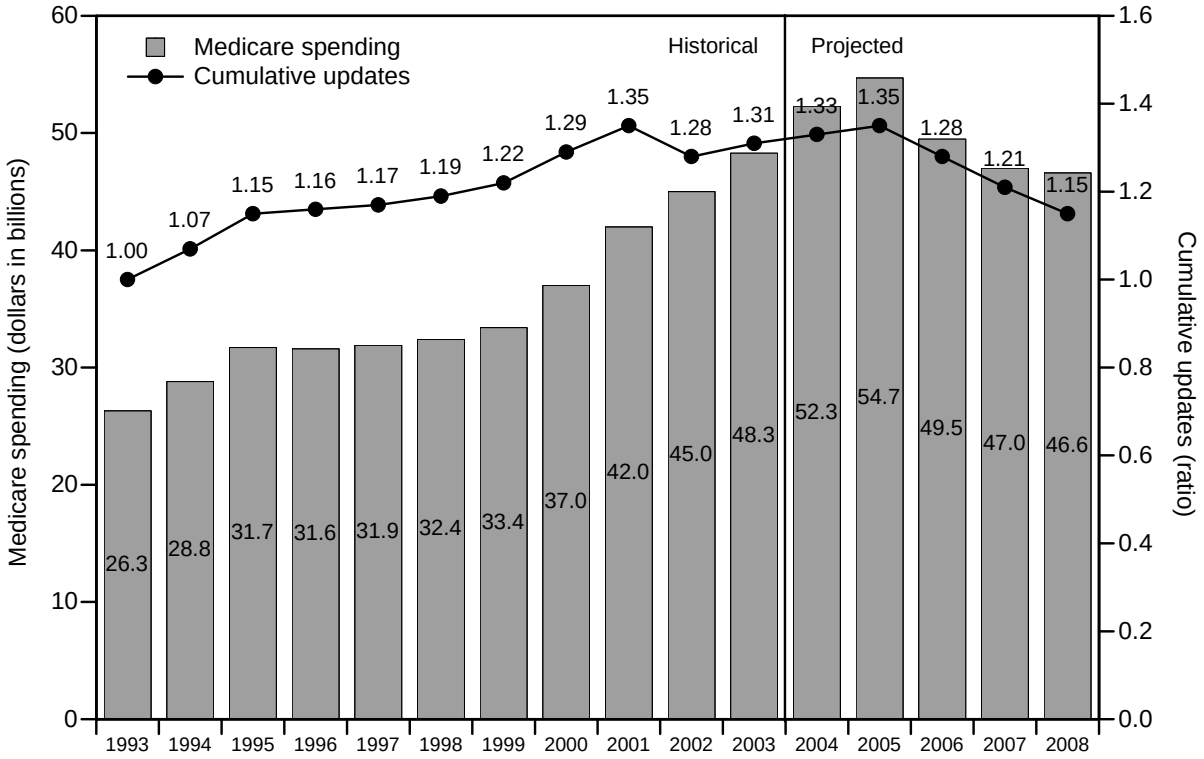
SECTION 8

Ambulatory care

Physicians
Hospital outpatient services
Ambulatory surgical centers
Independent diagnostic and testing facility services

Chart 8-1. FFS Medicare spending and payment updates for physician services, 1993–2008



Note: FFS (fee-for-service). Dollars are Medicare spending only, and do not include beneficiary coinsurance.

Source: MedPAC analysis of the 2004 annual report of the Boards of Trustees of the Medicare trust funds.

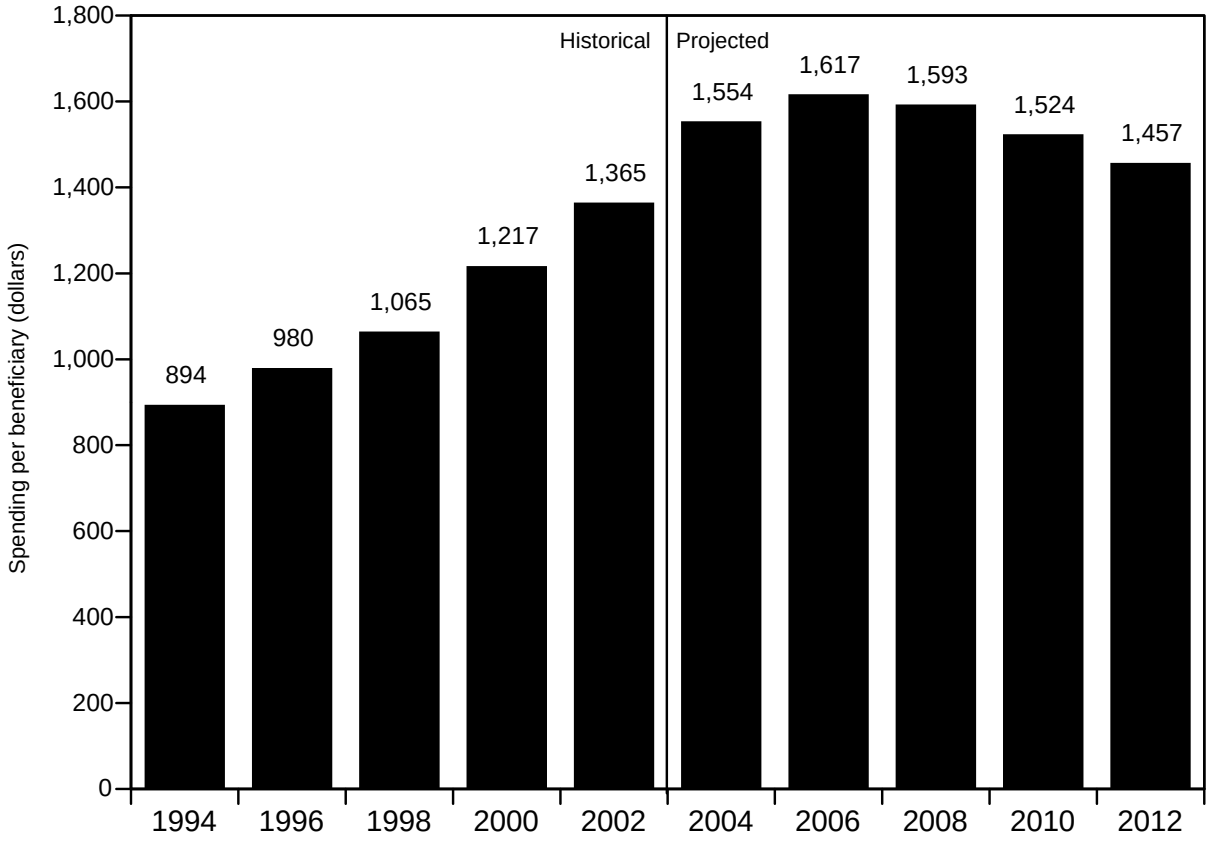
- Between 1993 and 1999, Medicare spending on physician services was relatively flat. More rapid growth occurred between 1999 and 2003—averaging 9.7 percent annually.

- The sustainable growth rate system (SGR) requires that future payment increases for physician services be adjusted for past actual physician spending relative to a target spending level. To avoid reductions in 2004 and 2005 physician fee schedule rates due to the SGR, the Medicare Modernization Act established minimum payment updates for physician services of 1.5 percent for 2004 and 2005. Under current law, payments for physician services are slated to decline about 5 percent for 7 consecutive years, beginning in 2006.

- Congressional testimony by the Chairman of MedPAC on physician payments and the SGR is available at http://www.medpac.gov/publications/congressional_testimony/050504_SGRTestimony_EC.pdf.

- A full copy of the Trustees report is available at http://cms.hhs.gov/publications/trusteesreport/default.asp.

Chart 8-2. Medicare spending per FFS beneficiary on physician services, 1994–2012



Note: FFS (fee-for-service). Dollars are Medicare spending only, and do not include beneficiary coinsurance.

Source: MedPAC analysis of the 2004 annual report of the Boards of Trustees of the Medicare trust funds.

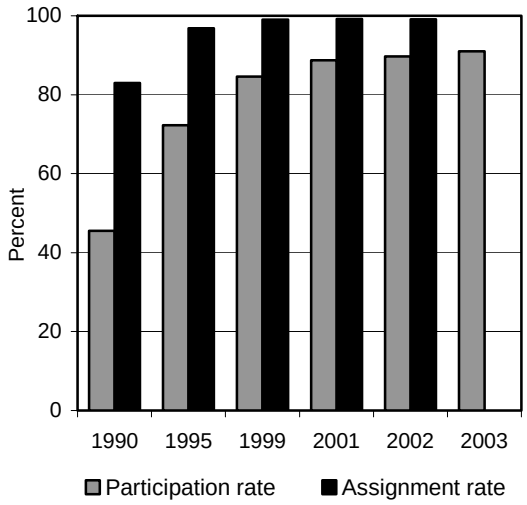
- Fee-for-service (FFS) physician spending per beneficiary has increased annually since 1994 and is expected to continue increasing through 2006.
- Under current law, FFS Medicare payments for physician services per beneficiary are projected to decline after 2006 because of scheduled negative payment updates. The volume of physician services per beneficiary, however, is expected to continue to grow.
- A full copy of the Trustees report is available at http://cms.hhs.gov/publications/trusteesreport/default.asp.
- Additional information on Medicare payment for physician services can be found in Chapter 3B of the MedPAC March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3B.pdf.

Chart 8-3. The supply of physicians furnishing services to beneficiaries has increased

Year	Number of physicians	Part B enrollment (millions)	Number of physicians per 1,000 beneficiaries
1995	460,700	35.641	12.9
1996	469,915	36.104	13.0
1997	476,164	36.445	13.1
1998	478,123	36.756	13.0
1999	484,576	37.022	13.1
2000	489,067	37.315	13.1
2001	494,718	37.657	13.1
2002	506,594	37.946	13.4

Note: FFS (fee-for-service). The numerator of the ratio of physicians per 1,000 beneficiaries includes allopathic and osteopathic physicians and excludes nurse practitioners, physician assistants, psychologists, and other health care professionals. The denominator is the number of beneficiaries enrolled in Medicare Part B, including FFS Medicare and Medicare+Choice, on the assumption that physicians are providing services to both types of beneficiaries.

Source: MedPAC analysis of unpublished CMS data.



Note: Participation rate is the percent of physicians signing Medicare participation agreements. Assignment rate is the percent of allowed charges paid on assignment. The assignment rate for 2003 is not shown; it requires calculations from claims not yet available.

Source: Ways and Means Greenbook (2000), unpublished CMS data, and MedPAC analysis of 2002 claims for a 5 percent random sample of Medicare beneficiaries.

- The number of physicians billing beneficiaries has more than kept pace with growth in the number of beneficiaries. From 1995 to 2002, the number of physicians billing fee-for-service Medicare grew by 10 percent, but Medicare Part B enrollment grew by 6.5 percent. This difference in growth rates led to an increase in the number of physicians per 1,000 beneficiaries, from 12.9 to 13.4. Note, however, that the number of beneficiaries in physicians' patient caseloads may vary considerably.

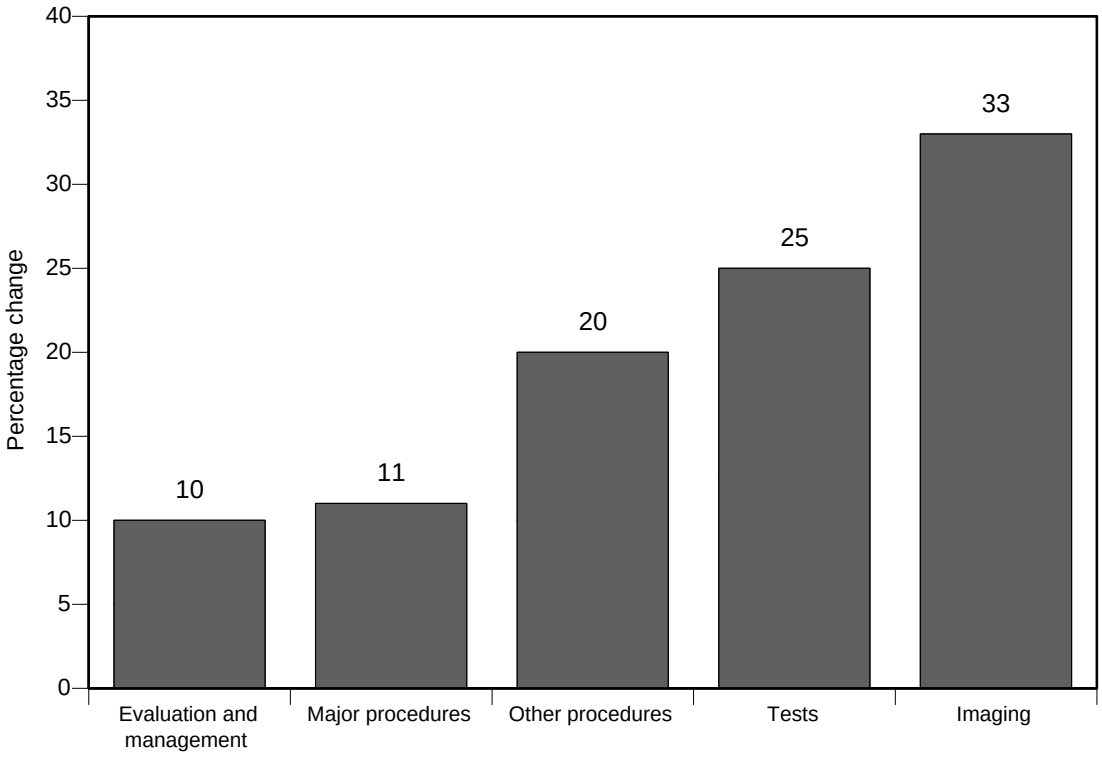
- A 2003 General Accounting Office report stated that between 1991 and 2001 the number of physicians in the U.S. increased by 26 percent—twice the rate of total population growth.

- The participation rate—the percentage of physicians who can bill Medicare and who agree to accept assignment on all claims for payment during a year—has risen steadily to 91 percent in 2003.

- When physicians accept assignment, they accept Medicare's fee schedule amount as the service's full charge (of which 20 percent is beneficiary coinsurance). In 2002, 99 percent of allowed charges for physician services were assigned.

- Additional information and analysis related to this topic can be found in Chapter 3B of the MedPAC March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3B.pdf.

Chart 8-4. Cumulative growth in volume per beneficiary, by type of service, 1999–2002



Source: MedPAC analysis of claims data for 100 percent of beneficiaries.

- Physician services can be classified by type of service. Evaluation and management services consist primarily of office visits but also include consultations and visits to patients in facility settings. Examples of procedures include open heart surgery, replacement of joints, and back surgery. Other procedures include colonoscopy, arthroscopy of the knee, and various eye procedures, such as cataract surgery. Tests range from analysis of specimens in a laboratory to electrocardiograms and cardiovascular stress tests. Imaging includes x-rays of the chest, the musculoskeletal system, and other parts of the body as well as more advanced procedures, such as computed tomography and MRI.

- Growth in the volume of physician services varies by type of service. From 1990 to 2002, volume growth was highest for imaging.

- It is unclear why volume is growing faster for some services than for others. Part of the explanation may relate to the nature of the services. The services with the highest growth rates tend to be more discretionary than other services. Some of the rapid growth could represent diffusion of technology, consumer demand, or practice patterns.

- Further analysis and information can be found in Chapter 4 of the MedPAC June 2003 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June03_Ch4.pdf.

Chart 8-5. Medicare Economic Index input categories, weights, and projected price changes for 2005

Input component	Category weight (percent)	Price changes for 2005 (percent)
Total	100.0%	3.3%
Physician work	**52.5**	**3.2**
Wages and salaries	42.7	3.1
Nonwage compensation	9.7	3.9
Practice expense	**47.5**	**3.3**
Nonphysician employee compensation	18.7	3.3
Wages and salaries	13.8	3.1
Nonwage compensation	4.8	4.1
Office expense	12.2	1.8
Professional liability insurance	3.9	8.9
Medical equipment	2.1	1.9
Drugs and supplies	4.3	2.5
Pharmaceuticals	2.3	2.9
Medical materials and supplies	2.0	1.9
Other professional expense	6.4	2.2

Note: Forecasted price changes for individual components are calculated by multiplying the component's weight by its price proxy. Forecasted price changes are not adjusted for productivity. Totals may not sum to 100 due to rounding.

Source: Unpublished fourth-quarter 2005 estimates from CMS dated February 27, 2004.

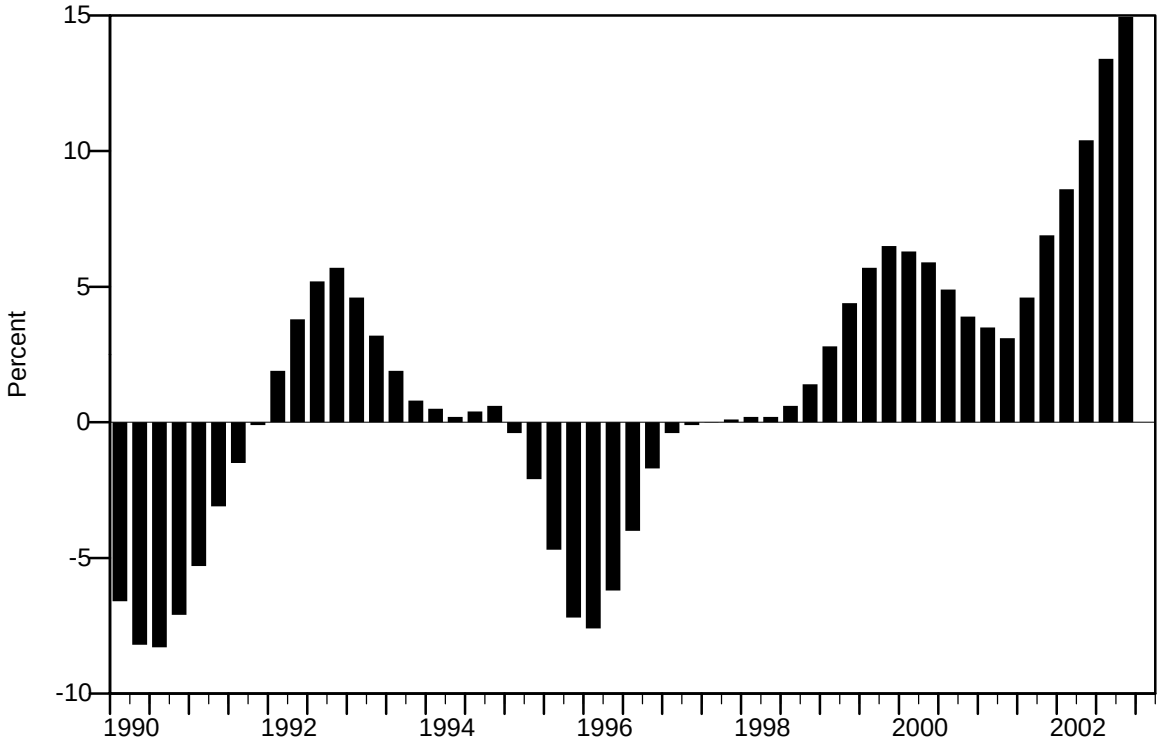
- An important factor in determining the payment update for physician services is the projected change in input prices for physician services as measured by the Medicare Economic Index (MEI). The MEI is a weighted average of price changes for physician time and effort (i.e., work) and practice expense.

- CMS projects that input prices for physician work will increase 3.2 percent in 2005, based on increases of 3.1 percent in wages and salaries and 3.9 percent in nonwage compensation. Practice expenses are projected to increase 3.3 percent. This projection primarily reflects a 3.3 percent increase in nonphysician employee compensation and a 1.8 percent increase in office expenses.

- Professional liability insurance has the largest projected price change, 8.9 percent.

- Additional information and analysis related to this topic can be found in Chapter 3B of the MedPAC March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3B.pdf.

Chart 8-6. Quarterly changes in professional liability insurance premiums, 1990–2003



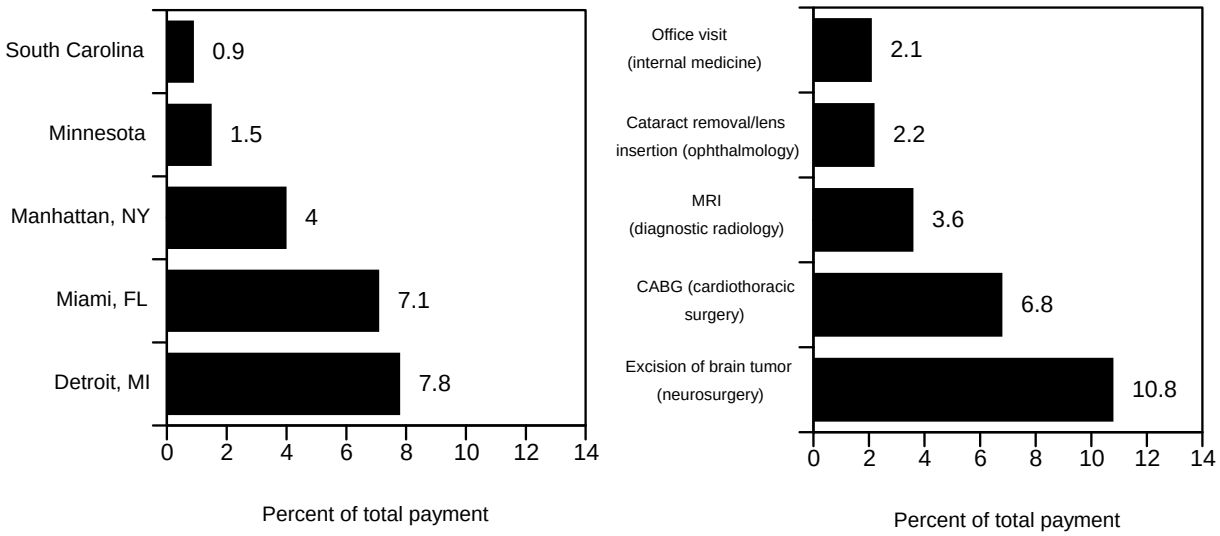
Source: Unpublished CMS data.

- Historically, the professional liability insurance (PLI) component of the Medicare Economic Index follows a strong cyclical pattern, illustrated by the changes in PLI premiums from1990 to 2001. The cycle is generally characterized by the periods of low premiums, perhaps when insurers are building market share, and high premiums, perhaps when insurers are building reserves.

- Since 2001, changes in PLI premiums have departed from this cyclical pattern. The increase in the second quarter of 2003, estimated at 16.8 percent, was the highest in over a decade.

- Additional information related to this topic can be found in MedPAC issue brief, available at http://www.medpac.gov/publications/other_reports/Aug03_PLI%20_2pgrKH.pdf.

Chart 8-7. PLI payments vary by locality and service, as a percentage of total payments under the Medicare fee schedule, 2002



Note: PLI (professional liability insurance), CABG (coronary artery bypass graft). PLI payments for services are national averages.

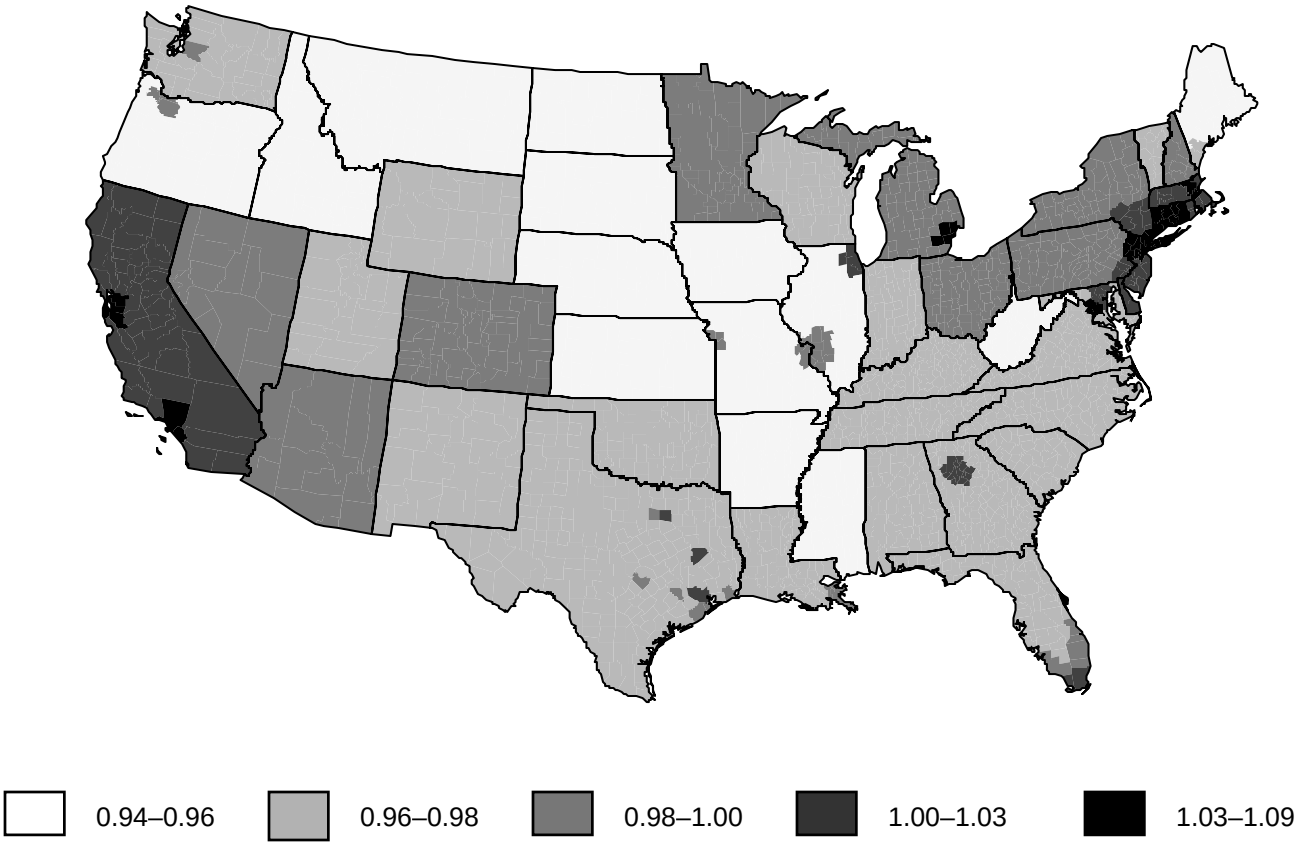
Source: MedPAC analysis of claims for 100 percent of Medicare beneficiaries in 2002.

- Medicare accounts for physicians' costs for professional liability insurance (PLI) in three ways. One way is through the Medicare Economic Index (MEI), which is used to adjust payments equally to account for PLI costs across all physicians serving Medicare beneficiaries. The other two ways are through the physician fee schedule, which assigns relative value units (RVUs) to services and geographic practice costs indexes (GPCIs) to areas of the country. These two components of the fee schedule allow Medicare payments to account for PLI differentially—by service and by geographic area—based on PLI premium differences.

- The fee schedule's RVUs designate higher payments for services furnished by neurosurgeons and cardiothoracic surgeons, who bear higher PLI premiums. Similarly, the fee schedule's GPCIs adjust payments to physicians who practice in geographic areas with high PLI premiums, such as Detroit, Michigan. Given both of these factors, over 20 percent of Medicare's payments to a Detroit neurosurgeon under the fee schedule can be attributable to PLI, if a fairly high proportion of the neurosurgeon's practice consists of major procedures.

- Additional information and analysis related to this topic can be found in Chapter 3B of the MedPAC March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3B.pdf.

Chart 8-8. Work GPCI before the MMA established a floor of 1.00



Note: GPCI (geographic practice cost index), MMA (Medicare Prescription Drug, Improvement, and Modernization Act of 2003).

Source: MedPAC analysis of geographic practice cost index from CMS.

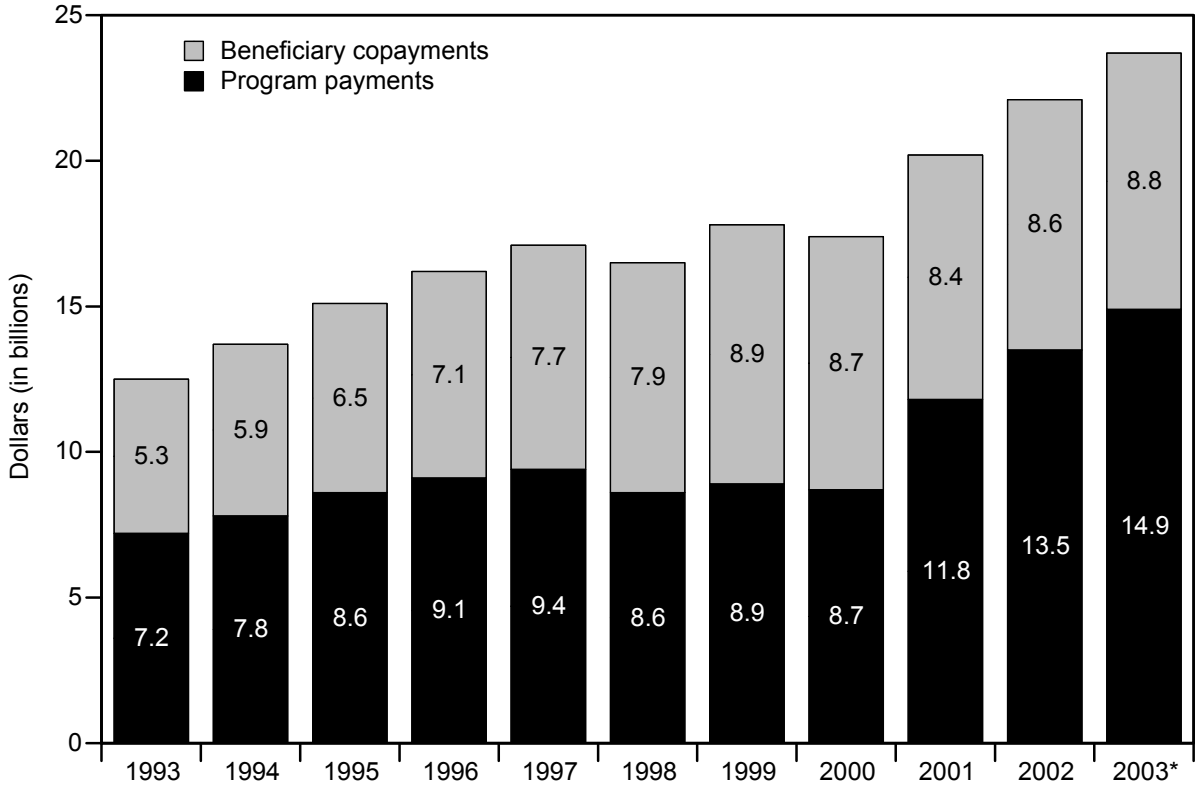
- Under Medicare's physician fee schedule, geographic practice cost indexes (GPCIs) adjust payment rates to account for differences in the price of inputs used in furnishing physician services. There are three GPCIs, one corresponding to each component of the relative value scale: Physician work, practice expense, and professional liability insurance (PLI). The three GPCIs are applied to determine rates for each of 89 payment areas.

- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a floor for the work GPCI of 1.00. The floor is in effect from 2004 through 2006. Before the MMA, the work GPCI ranged from 0.94 to 1.09.

- For Alaska the MMA established a floor of 1.67 for all three GPCIs for 2004 and 2005. Previously, the work, practice expense, and PLI GPCIs for the state were 1.06, 1.17, and 1.22, respectively.

- Additional information on the GPCIs can be found in a MedPAC issue brief available at http://www.medpac.gov/publications/other_reports/Aug03_GPCI_2pgrKH.pdf.

Chart 8-9. Spending on all hospital outpatient services, 1993–2003



Note: * Estimate. Spending amounts are for services covered by the Medicare outpatient prospective payment system and those paid on separate fee schedules (such as ambulance services or durable medical equipment) or those paid on a cost basis (such as organ acquisition or flu vaccines). They do not include payments for clinical laboratory services.

Source: CMS, Office of the Actuary.

- Overall spending by Medicare and beneficiaries on hospital outpatient services almost doubled from calendar year 1993 to 2003. Growth was fast early in the 1990s, slowed in the mid-1990s, and accelerated again in 2001. The Office of the Actuary projects continued growth in total spending, averaging 8.6 percent per year from 2002 to 2007.

- A prospective payment system (PPS) for hospital outpatient services was implemented in August 2000. Services paid under the outpatient PPS represent about 90 percent of spending on all hospital outpatient services (excluding clinical laboratory services which is paid under a fee schedule).

- In 2001, the first full year of the outpatient PPS, spending under the PPS was $18.4 billion, including $10.4 billion by the program and $8.0 billion in beneficiary cost sharing. By 2003, spending under the outpatient PPS is expected to rise to $21.6 billion ($13.3 billion program spending; $8.3 billion beneficiary copayments). The outpatient PPS accounted for about 6 percent of total Medicare spending by the program and beneficiaries in 2003.

- Beneficiary cost sharing under the outpatient PPS is generally higher than for other sectors, about 38 percent in 2003. Chart 8-14 provides more detail on coinsurance.

Chart 8-10. Providers of hospital outpatient services

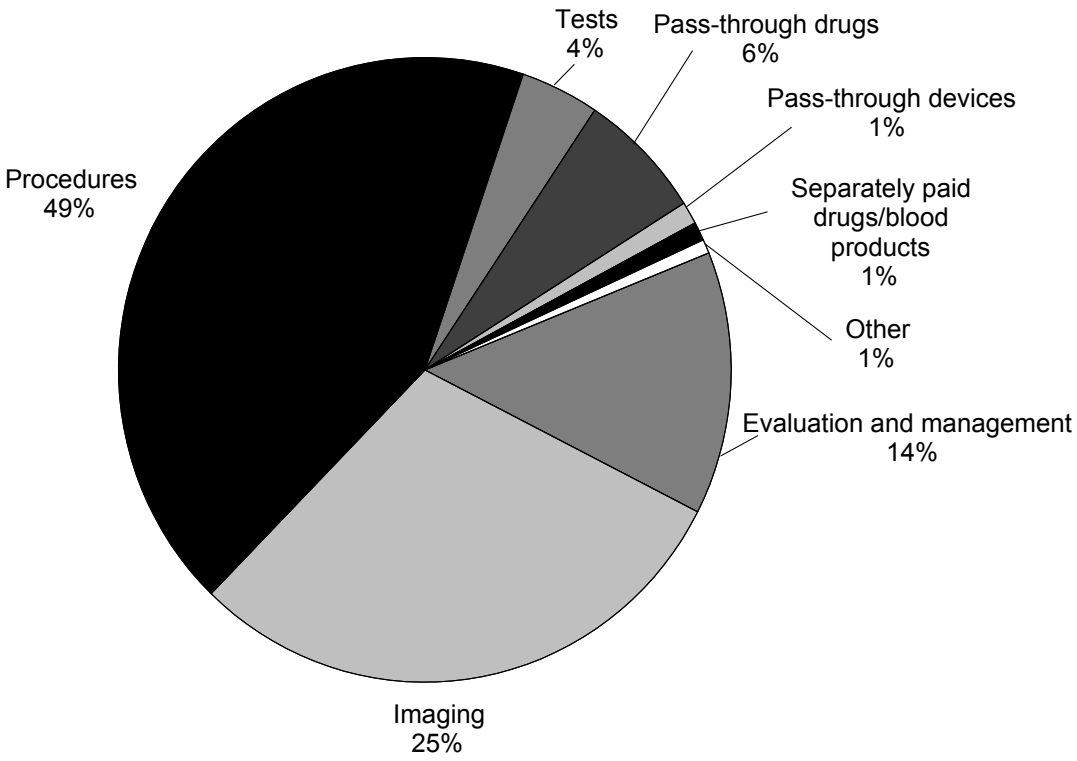
Year	Hospitals	Percent offering		
		Outpatient services	Outpatient surgery	Emergency services
1991	5,191	92%	79%	91%
1997	4,976	93	81	92
2001	4,347	94	84	93
2002	4,210	94	84	93

Note: Excludes long-term and alcohol- and drug-abuse hospitals, as well as critical access hospitals. Includes all others paid under the outpatient prospective payment system.

Source: MedPAC analysis of the Medicare provider of services file from CMS.

- While the number of hospitals has fallen over the past decade, the percent providing outpatient services, outpatient surgery, and emergency services has grown.
- Almost all hospitals provide outpatient (94 percent) and emergency (93 percent) services. The vast majority (84 percent) provides outpatient surgery.
- The share of hospitals providing outpatient services did not change after the introduction of the outpatient prospective payment system.

Chart 8-11. Payments under the Medicare hospital outpatient PPS, by type of service, 2002



Note: PPS (prospective payment system). Payments include both program spending and beneficiary cost sharing, but do not include transitional corridor payments. Services are grouped into evaluation and management, procedures, imaging, tests, and other categories according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and devices and separately paid drugs and blood products are classified by their payment status indicator. Percents do not sum to 100 due to rounding.

Source: MedPAC analysis of the 100 percent special analytic file of outpatient PPS claims for April to December 2002 from CMS.

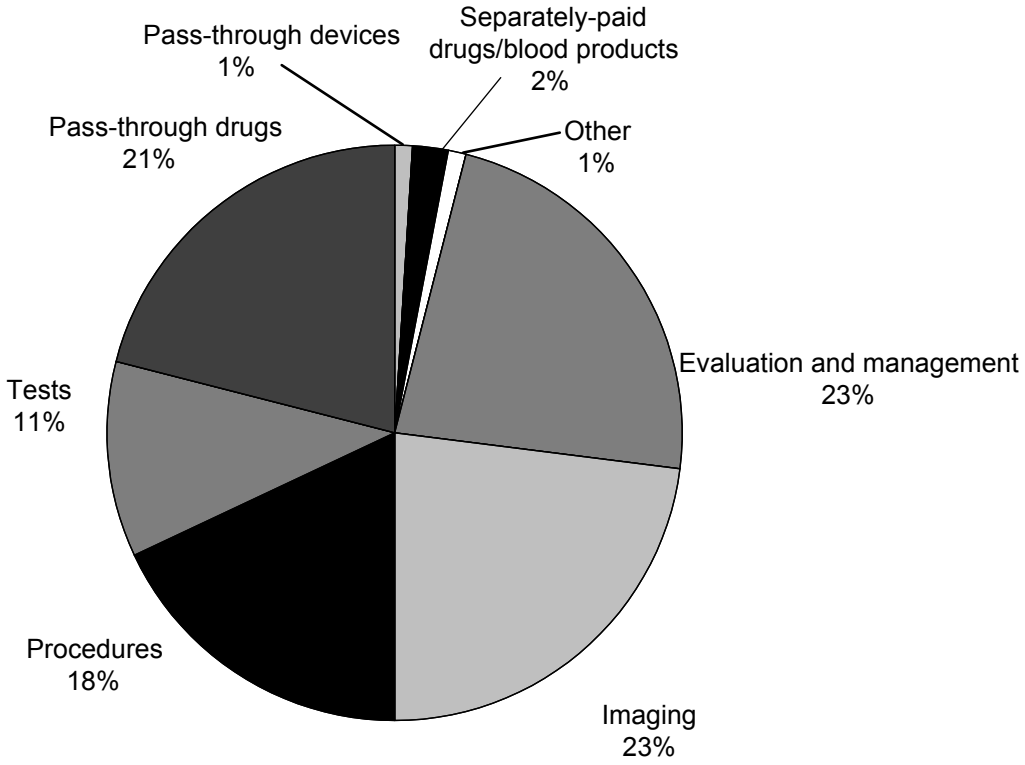
- Hospitals provide many different types of services in their outpatient departments, including emergency and clinic visits, imaging and other diagnostic services, laboratory tests, and ambulatory surgery.

- Procedures (e.g. endoscopies, surgeries, skin and musculoskeletal procedures) account for the greatest share of spending on services (49 percent), followed by imaging services (25 percent), and evaluation and management (14 percent).

- In 2002, pass-through drugs and devices accounted for 6 percent of spending. Payments for pass-through drugs include both the base payment and the pass-through amount.

- More information on pass-through payments can be found in Chapter 4 of the MedPAC March 2003 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar03_Ch4.pdf.

Chart 8-12. Volume of services under the Medicare hospital outpatient PPS, by type of service, 2002



Note: PPS (prospective payment system). Services are grouped into evaluation and management, procedures, imaging, tests, and other categories according to the Berenson-Eggers type of service classification developed by CMS. Pass-through drugs and devices and separately-paid drugs and blood products are classified by their payment status indicator.

Source: MedPAC analysis of 100 percent special analytic file of outpatient PPS claims for April to December 2002 from CMS.

- Almost half of the services provided in hospital outpatient departments are evaluation and management or imaging services.
- The volume of services is distributed differently than payments. For example, procedures account for 18 percent of the volume, but 49 percent of the payments (see Chart 8-11).

Chart 8-13. Hospital outpatient services with the highest Medicare expenditures, 2002

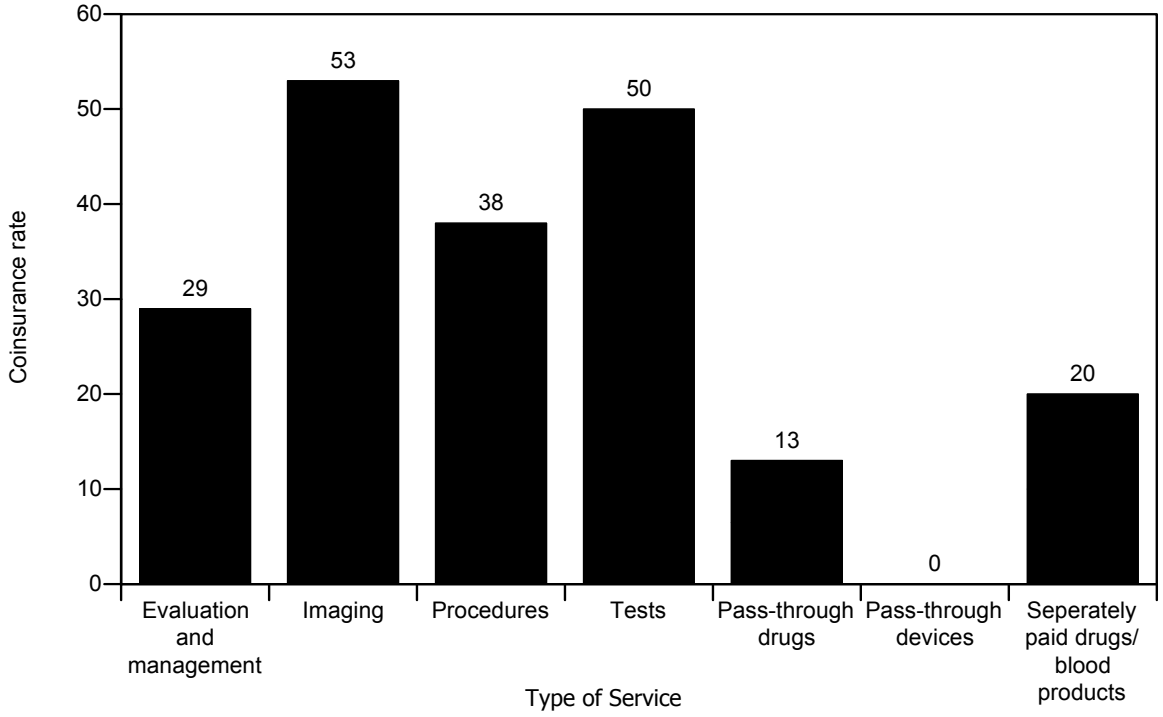
APC	Title	Share of payments
610, 611, 612	All emergency visits	7%
0246	Cataract procedures with lens insert	5
600, 601, 602	All clinic visits	4
0283	Computerized axial tomography (CAT) with contrast material	4
0080	Diagnostic cardiac catheterization	4
0143	Lower gastrointestinal endoscopy	3
0260	Level I plain film (X-ray) except teeth	3
0286	Myocardial scans	3
0332	Computerized axial tomography and computerized angiography	2
0300	Level I radiation therapy	2
0269	Level I echocardiogram except transesophageal	2
0120	Infusion therapy except chemotherapy	2
0336	Magnetic resonance imaging and magnetic resonance angiography	2
0141	Upper gastrointestinal procedures	2
0280	Level II angiography and venography except extremity	1
0337	MRI and magnetic resonance angiography without contrast	1
0154	Hernia/hydrocele procedures	1
0333	CAT and computerized angiography without contrast material followed by contrast	1
0325	Group psychotherapy	1
0359	Level II injections	1
Total		50

Note: APC (ambulatory payment classification). Payments include both program spending and beneficiary cost sharing.

Source: MedPAC analysis of the 100 percent special analytic file of outpatient prospective payment system claims for April to December 2002 from CMS.

- Although the outpatient prospective payment system covers thousands of services, expenditures are concentrated in a handful of categories that have high volume, high payment rates, or both.

Chart 8-14. Medicare coinsurance rates, by type of hospital outpatient service, 2002



Note: Services were grouped into categories of evaluation and management, procedures, imaging, and tests according to the Berenson-Eggers Type of Service classification developed by CMS. Pass-through drugs and devices and separately paid drugs and blood products are classified by their payment status indicators.

Source: MedPAC analysis of 100 percent special analytic file of 2002 outpatient prospective payment system claims and payment rates.

- Historically, beneficiary coinsurance payments for hospital outpatient services were based on hospital charges, while Medicare payments were based on hospital costs. As hospital charges grew faster than costs, coinsurance represented a large share of total payment over time.

- In adopting the outpatient prospective payment system (PPS), the Congress froze the dollar amounts for coinsurance. Consequently, beneficiaries' share of total payments will decline over time.

- The coinsurance rate is different for each service. Some services, such as imaging and tests, have very high rates of coinsurance—50 percent or more. Other services, such as clinic visits, have coinsurance rates of 20 percent.

- In 2002, the overall coinsurance rate was about 39 percent.

- A description of coinsurance under the outpatient PPS can be found in Chapter 9 of the MedPAC March 2001 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar01%20Ch9.pdf.

Chart 8-15. Transitional corridor payments as a share of Medicare hospital outpatient payments, 2001 and 2002

Hospital group	2001 Number of hospitals	2001 Share of payments from transitional corridors	2002 Number of hospitals	2002 Share of payments from transitional corridors
All hospitals	3,388	2.3%	2,091	2.6%
Urban	2,121	2.1	1,337	2.3
Rural ≤ 100 beds	990	4.7	584	6.4
Rural > 100 beds	272	0.8	167	1.8
Major teaching	249	4.9	137	4.7
Other teaching	700	1.2	436	1.6
Nonteaching	2,434	1.9	1,515	2.5

Note: A small number of hospitals could not be classified due to missing data. The 2002 file includes about 60 percent of hospitals. The 2002 results have not been adjusted to be representative of all hospitals.

Source: MedPAC analysis of Medicare Cost Report file from CMS.

- When Medicare implemented the hospital outpatient prospective payment system (PPS) in 2000, Medicare moved from paying hospitals based on their costs to a payment schedule based on average (median) costs for all hospitals.

- Recognizing that some hospitals might receive lower payments under the outpatient PPS than they had under the earlier system, the Congress included a transition mechanism, called transitional corridor payments. The corridors were designed to make up part of the difference between payments that hospitals would have received under the old payment system and those under the new outpatient PPS. To provide incentives for efficiency, Medicare did not compensate the full difference, except for rural hospitals with 100 or fewer beds, cancer hospitals, and children's hospitals.

- Transitional corridor payments represented 2.3 percent of total outpatient PPS payments in 2001, growing to 2.6 percent in 2002.

- Rural hospitals, particularly those with 100 or fewer beds, received a relatively large share of their payments from transitional corridors.

- Major teaching hospitals also reported greater shares of transitional corridor payments, receiving just under 5 percent of their payments from this source.

Chart 8-16. Three quarters of outpatient outlier payments were for services with payment rates of $300 or less in 2002

Payment rate	Percent of outlier payments	Percent of APC payments
Less than $50	24.1%	10.9%
$50 to $99	9.7	10.3
$100 to $199	26.0	21.5
$200 to $299	15.0	11.4
$300 to $399	8.6	8.0
$400 to $499	2.1	3.4
$500 to $999	6.9	7.4
$1000 or more	7.6	26.2

Note: APC (ambulatory payment classification). Percent of APC payments does not sum to 100 because some services (such as pass-through items) do not have a payment rate.

Source: MedPAC analysis of Special Analytic file of 100 percent of outpatient prospective payment system claims for April through December 2002 from CMS.

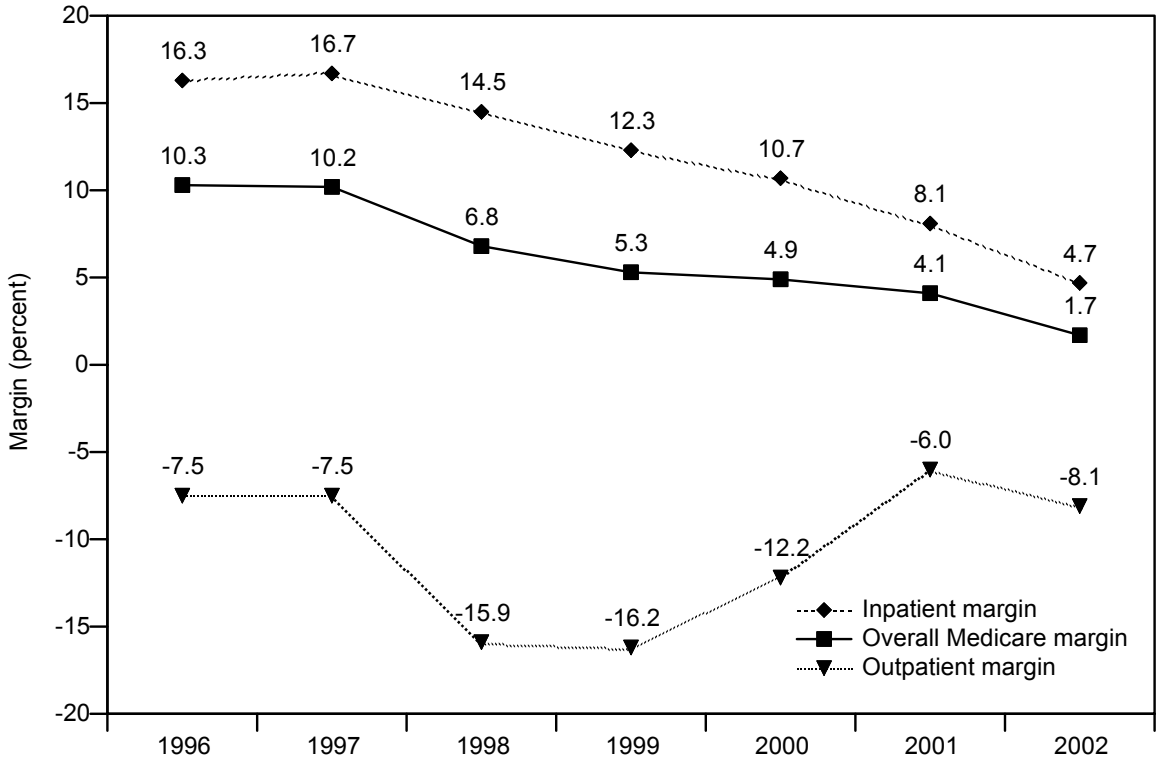
- The outpatient prospective payment system (PPS) has an outlier payment policy to provide additional payments to hospitals when they treat patients with extraordinarily high costs compared to their Medicare payments. The outlier policy is meant to serve as a form of insurance, protecting hospitals from large financial losses, and thereby protecting access to care for beneficiaries.

- Under the outpatient PPS, the outlier payments are based on the costs of an individual patient compared to the payment rate for the service, regardless of the level of the payment rate. Many services provided in outpatient departments have low payment rates.

- In 2002, 75 percent of outlier payments were for services with payment rates of $300 or less. Services with payments less than $50 accounted for 24 percent of outlier payments. At the other end of the spectrum, services with payment rates greater than $1,000 account for less than 8 percent of outlier payments. This distribution of outlier payments indicates that, in general, outlier payments are not protecting hospitals from significant financial losses as intended.

- A discussion of the outlier policy under the outpatient PPS can be found in Chapter 3A of the MedPAC March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3A.pdf.

Chart 8-17. Medicare hospital outpatient, inpatient, and overall Medicare margins, 1996–2002



Note: A margin is calculated as revenue minus costs, divided by revenue. Data are based on Medicare-allowable costs and imputed for hospitals for which 2002 cost reports were not available. Analysis excludes critical access hospitals. Overall Medicare margins cover the costs and payments of hospital inpatient, outpatient, psychiatric and rehabilitation (not paid under the prospective payment system), skilled nursing facilities, and home health services, as well as graduate medical education.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

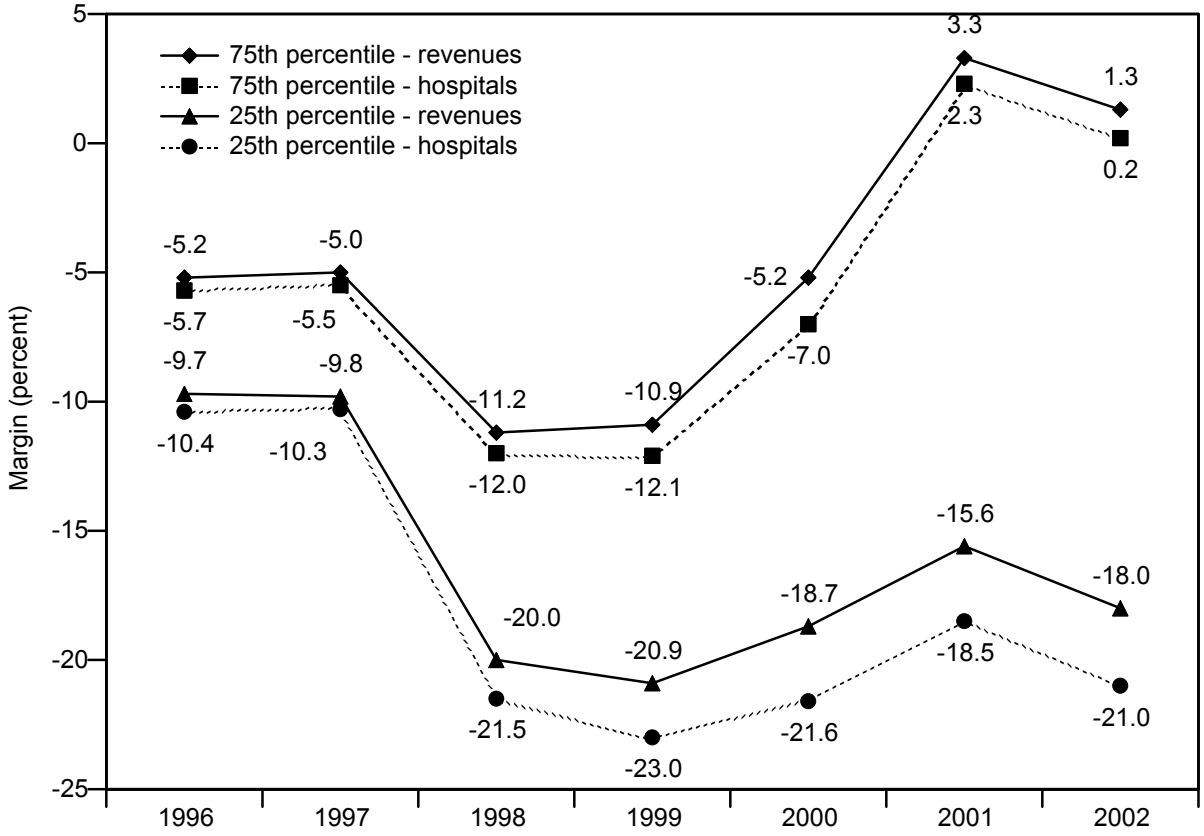
- Given hospital accounting practices, margins for hospital outpatient services must be considered in the context of Medicare payments and hospital costs for the full range of services provided to Medicare beneficiaries. When inpatient services were paid prospectively and outpatient services were paid based on costs, hospitals had a strong incentive to allocate joint costs to outpatient services on their cost reports.

- As a result, inpatient may be overstated and outpatient margins may be understated. These allocation decisions may have greater effects on the outpatient margin, however, because revenues for outpatient services represent a smaller share of the total (about 15 percent) than do inpatient revenues (about 75 percent). To avoid these allocation problems, MedPAC generally uses the overall Medicare margin to assess overall payment adequacy for hospital services.

- The dip in outpatient margins in 1998 is due primarily to the elimination of inadvertent overpayments. These overpayments resulted from an error in payment formulas for certain services that did not adequately account for beneficiary coinsurance when determining program payments.

- The improvement in outpatient margins from 1999 to 2001 is consistent with policies implemented under the outpatient prospective payment system that increased payments. Margins declined somewhat from 2001 to 2002.

Chart 8-18. Distribution of hospital outpatient margins, 1996–2002



Note: A margin is calculated as revenue minus costs, divided by revenue. The margins are presented for individual hospitals and weighted by revenues. Data are not available to weight by services or patients. Data are based on Medicare-allowable costs and imputed for hospitals for which 2002 cost reports were not available. Analysis excludes critical access hospitals.

Source: MedPAC analysis of Medicare cost report data (third quarter 2003) from CMS.

- Hospital outpatient margins vary. While the aggregate margin was –8.1 percent in 2002 (see Chart 8-17), 25 percent of hospitals had margins of –21.0 percent or lower, and 25 percent had margins of 0.2 percent or higher.

- When the margins are weighted by revenues, to account for where program dollars are spent, they rise. Using this measure, the 25th percentile was –18.0 percent and the 75th percentile was 1.3 percent in 2002.

- In the period since the implementation of the outpatient prospective payment system, margins rose both in the aggregate and for the 75th percentile, with a downturn in 2002. Gains were smaller for the 25th percentile.

- MedPAC-sponsored research suggests that hospital accounting practices have led to an overstatement of outpatient costs by as much as 15 to 20 percent. As a consequence, outpatient margins are probably understated. (Chapter 3A of the MedPAC 2004 March Report to the Congress is available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3A.pdf.)

Chart 8-19. Medicare-certified ASCs increased over 50 percent, 1997–2003

	1997	1998	1999	2000	2001	2002	2003
Medicare payments (billions of dollars)	1.0	1.1	1.2	1.4	1.6	1.9	2.2
Number of centers	2,462	2,644	2,786	3,028	3,371	3,597	3,735
New centers	237	228	162	295	445	309	185
Exiting centers	40	46	20	53	103	83	47
Net percent growth from previous year	8.7%	7.4%	5.4%	8.7%	11.3%	6.7%	3.8%
	Percent of all centers						
For profit	93%	94%	94%	94%	94%	95%	95%
Nonprofit	6	6	6	6	5	5	5
Urban	90	89	89	88	88	87	87
Rural	10	11	11	12	12	13	13

Note: ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Payments for 2003 are projected. For 2003, data on the number of facilities are through June. For all other years, data are through December. Totals may not sum to 100 due to rounding.

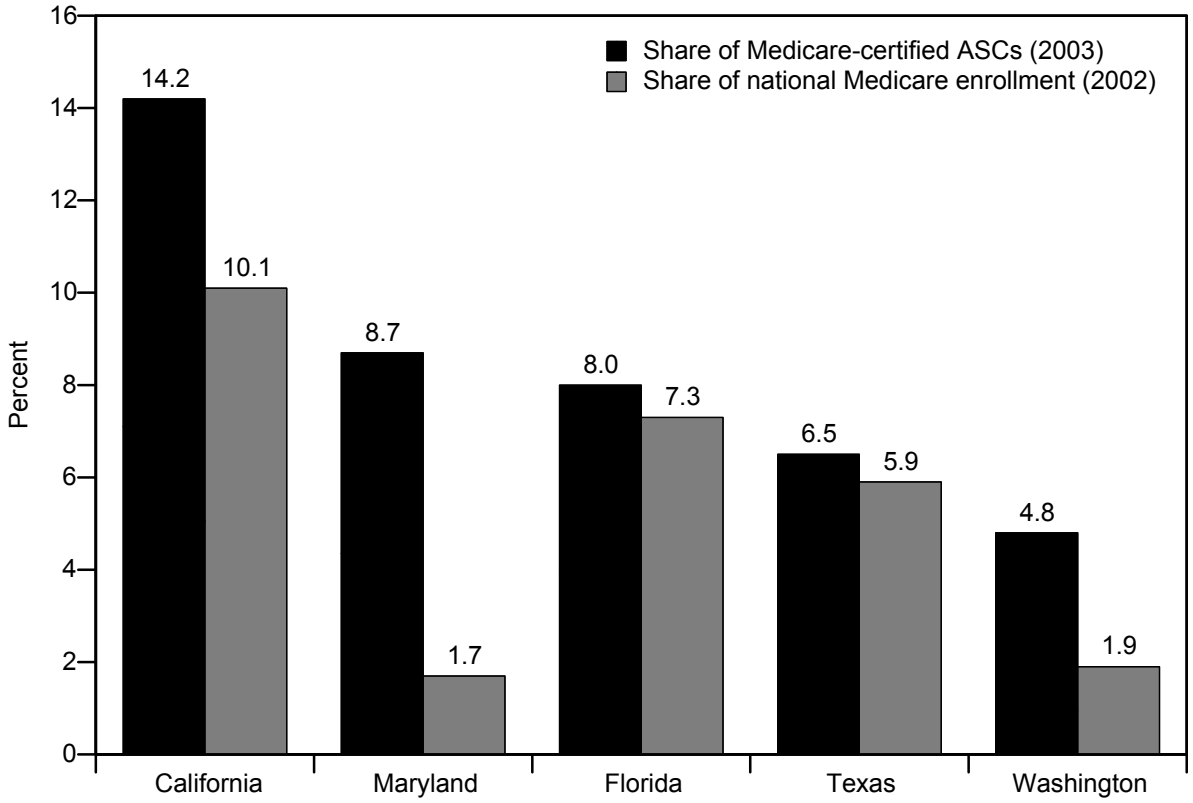
Source: MedPAC analysis of provider of services file from CMS, payment data from CMS, Office of the Actuary.

- Ambulatory surgical centers (ASCs) are distinct entities that only furnish outpatient surgical services not requiring an overnight stay. To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage, which specify minimum clinical standards.

- The number of Medicare-certified ASCs grew at an average annual rate of 8 percent from 1997 through the first half of 2003. Each year from 1997 through 2002, an average of 279 new Medicare-certified facilities entered the market, while an average of 58 closed or merged with other facilities.

- The overwhelming majority of Medicare-certified ASCs are for-profit facilities and are located in urban areas.

Chart 8-20. Over 40 percent of Medicare-certified ASCs are located in 5 states, 2003



Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of provider of services file from CMS, enrollment data from CMS, Office of the Actuary.

- Five states accounted for 42 percent of Medicare-certified ambulatory surgical centers in 2003, 38 percent of ASC services received by beneficiaries (2002), but only 27 percent of Medicare beneficiaries (2002).

Chart 8-21. Ophthalmology and gastroenterology procedures accounted for over two-thirds of ASC services provided to beneficiaries, 2002

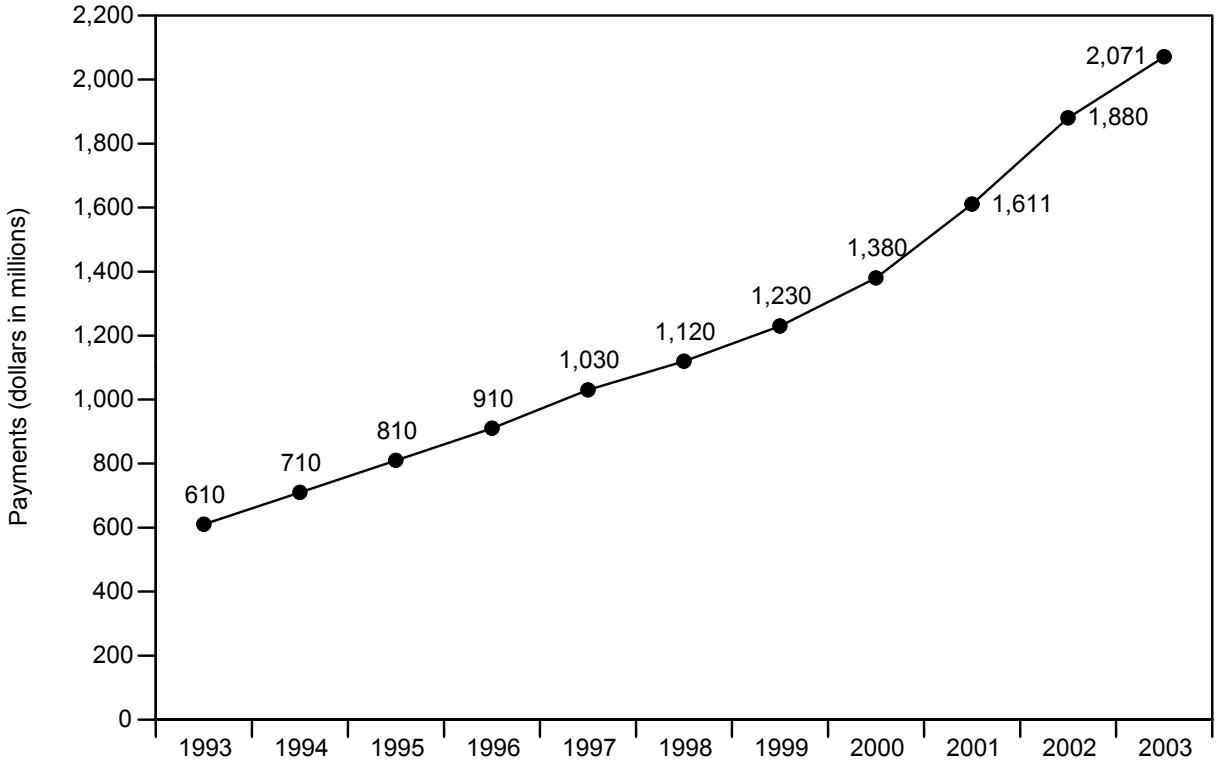
Procedure category	Medicare volume (percent of total)	Medicare ASC payments (percent of total)	Medicare payments (millions)	Percent volume growth, 2001–2002
Cataract removal and lens insertion	27.4%	47.5%	$904	11.5%
Colonoscopy	19.5	14.8	282	27.8
Other eye procedures	11.3	9.3	176	10.9
Minor procedures – musculoskeletal	11.0	5.8	111	28.9
Upper gastrointestinal endoscopy	10.3	6.7	128	20.1
Other ambulatory procedures	4.5	3.0	56	17.9
Ambulatory procedures – musculoskeletal	3.5	2.6	50	18.8
Cystoscopy	2.8	1.9	36	9.6
Ambulatory procedures – skin	1.6	1.2	24	9.7
Arthroscopy	1.6	1.5	29	-0.2
Other services	6.5	5.6	106	29.0
Total	100.0	100.0	1,902	18.2

Note: ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing. Other eye procedures includes after-cataract laser surgery. Minor procedures – musculoskeletal includes interventional pain management procedures (such as epidural injection and facet joint block), soft tissue biopsy, and tumor excision. Other ambulatory procedure includes breast biopsy, nasal polyp excision, abscess drainage, nerve graft, and ear surgery. Ambulatory procedures – musculoskeletal includes hammertoe operation, arthrotomy, tenotomy, and tendon repair. Ambulatory procedures – skin includes debridement, excision of lesion, wound repair, and skin graft. Other services includes other endoscopic, orthopedic, eye, and skin procedures, as well as hernia repair. Totals may not sum to 100 due to rounding.

Source: MedPAC analysis of the 5 percent Standard Analytic File of ASC claims from CMS, 2001 and 2002, and the Berenson-Eggers Type of Service classification scheme developed by CMS.

- Taken together, eye procedures (cataract removal and lens insertion and other eye procedures) account for almost 40 percent of the volume of ASC procedures and almost 60 percent of Medicare payments for ASC services.
- Colonoscopy and upper gastrointestinal endoscopy account for 30 percent of volume and 20 percent of Medicare payments.
- CMS maintains a list of over 2,400 surgical procedures eligible for facility payment by Medicare when performed in an ASC. Procedures must meet specific clinical and volume criteria to be added to this list. The list of approved procedures was most recently updated in 2003.

Chart 8-22. Medicare payments to ASCs more than tripled, 1993–2003

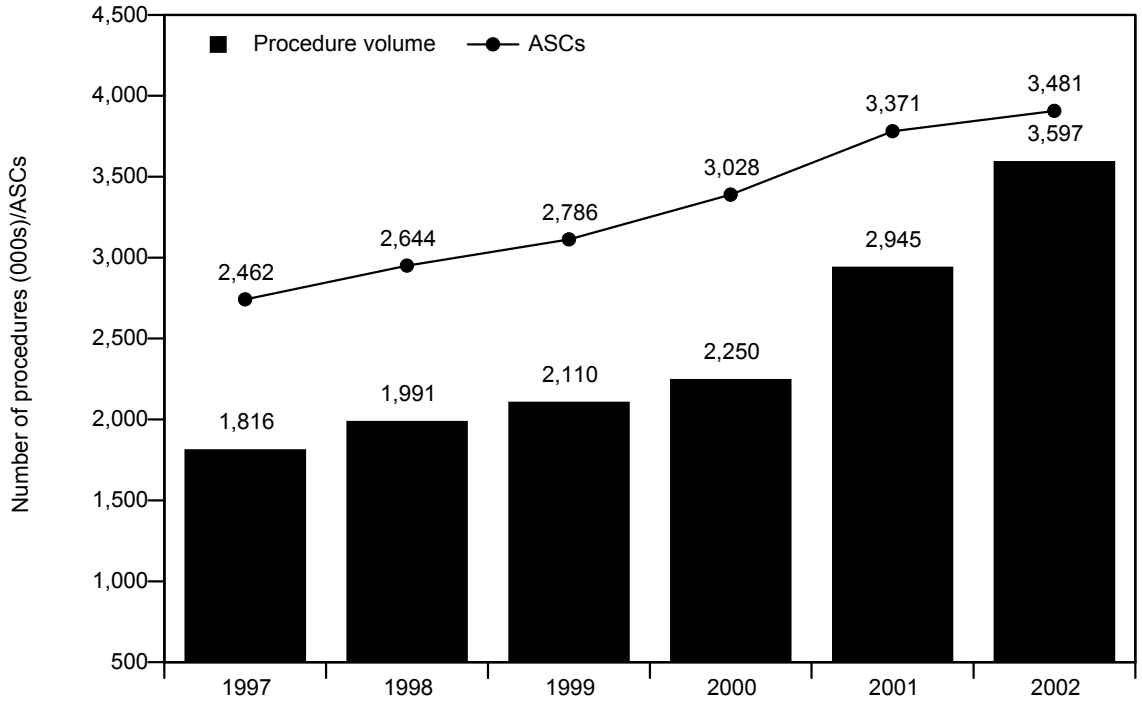


Note: ASC (ambulatory surgical center). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Average annual growth of payments (1993–2003) equals 13 percent.

Source: CMS, Office of the Actuary, 2004.

- Payments to ambulatory surgical centers increased from $610 million to $2 billion in 10 years, but are still less than 1 percent of total Medicare spending.
- More information on Medicare's payment policy for ASC services can be found in Chapter 3F of MedPAC's March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3F.pdf.

Chart 8-23. ASCs and the volume of ASC procedures have grown rapidly, 1997–2002



Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of provider of services file, 5 percent Standard Analytic File of ASC claims from CMS.

- Between 1997 and 2002, the volume of ambulatory surgical center (ASC) procedures provided to Medicare beneficiaries increased by 90 percent (14 percent per year, on average), while the number of Medicare-certified ASCs increased by 46 percent (8 percent per year, on average).

- The number of ASC procedures per thousand beneficiaries grew from 47 to 86 (82 percent) during the same period.

Chart 8-24. Over half of most common ambulatory surgical procedures were performed in hospital outpatient departments, 2001

Procedure category	Share of ambulatory surgical volume, all settings	Share of volume, by setting: Outpatient departments	Physician offices	ASCs
Colonoscopy	16.0%	70.8%	4.3%	24.9%
Cataract removal and lens insertion	12.5	47.7	0.5	51.8
Minor procedures—musculoskeletal	10.7	48.1	31.1	20.8
Upper gastrointestinal endoscopy	9.5	72.0	4.5	23.5
Cystoscopy	9.0	28.7	63.8	7.5
Ambulatory procedures—skin	7.9	42.4	52.6	5.0
Other ambulatory procedures	7.3	69.8	16.5	13.8
Other eye procedures	6.9	27.5	33.6	39.0
Other minor procedures	5.0	30.1	63.3	6.5
Ambulatory procedures—musculoskeletal	3.4	59.8	17.4	22.9
Total	88.1	53.1	24.1	22.8

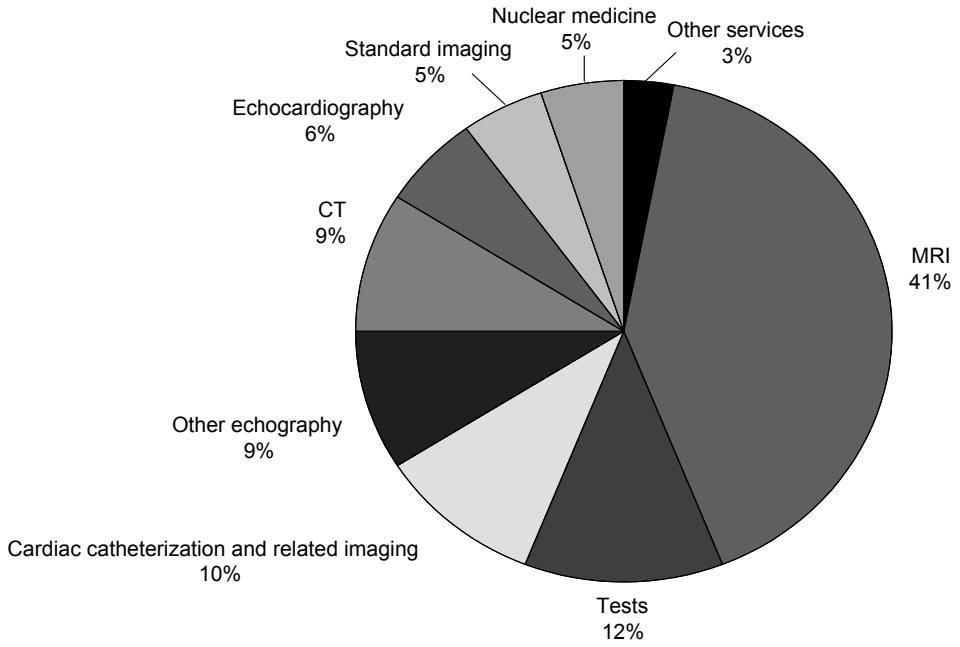
Note: ASC (ambulatory surgical center). Table only includes ambulatory surgical procedures that are on the list of services payable by Medicare when performed in an ASC. Procedure categories are arranged by their share of ambulatory surgical volume across all settings, from highest to lowest. Minor procedures – musculoskeletal includes interventional pain management procedures (such as epidural injection and facet joint block), soft tissue biopsy, and tumor excision. Ambulatory procedures – skin includes skin debridement, excision of lesion, wound repair, and skin graft. Other ambulatory procedures includes breast biopsy, nasal polyp excision, abscess drainage, and nerve graft. Other eye procedures includes after-cataract laser surgery. Other minor procedures includes nasal, oral, urological, and nerve procedures. Ambulatory procedures – musculoskeletal includes hammertoe operation, arthrotomy, tenotomy, and tendon repair.

Source: MedPAC and RAND analysis of the 5 percent Standard Analytic Files of physician, outpatient department, and ASC claims from CMS and the Berenson-Eggers Type of Service classification scheme developed by CMS.

- Outpatient departments account for 71 percent of colonoscopies—the most common ambulatory surgical procedure.
- Over half of cataract removal and lens insertion procedures are provided in ASCs.
- Physician offices account for a majority of cystoscopies, ambulatory procedures–skin, and other minor procedures.

Chart 8-25. Medicare spending for independent diagnostic testing facility services, by type of service, 2002

Total spending = $741 million



Note: CT (computed tomography), MRI (magnetic resonance imaging). Tests include electrocardiogram monitoring and cardiovascular stress tests but excludes clinical laboratory tests. Cardiac catheterization includes placement of the catheter and the related imaging procedure, such as angiogram.

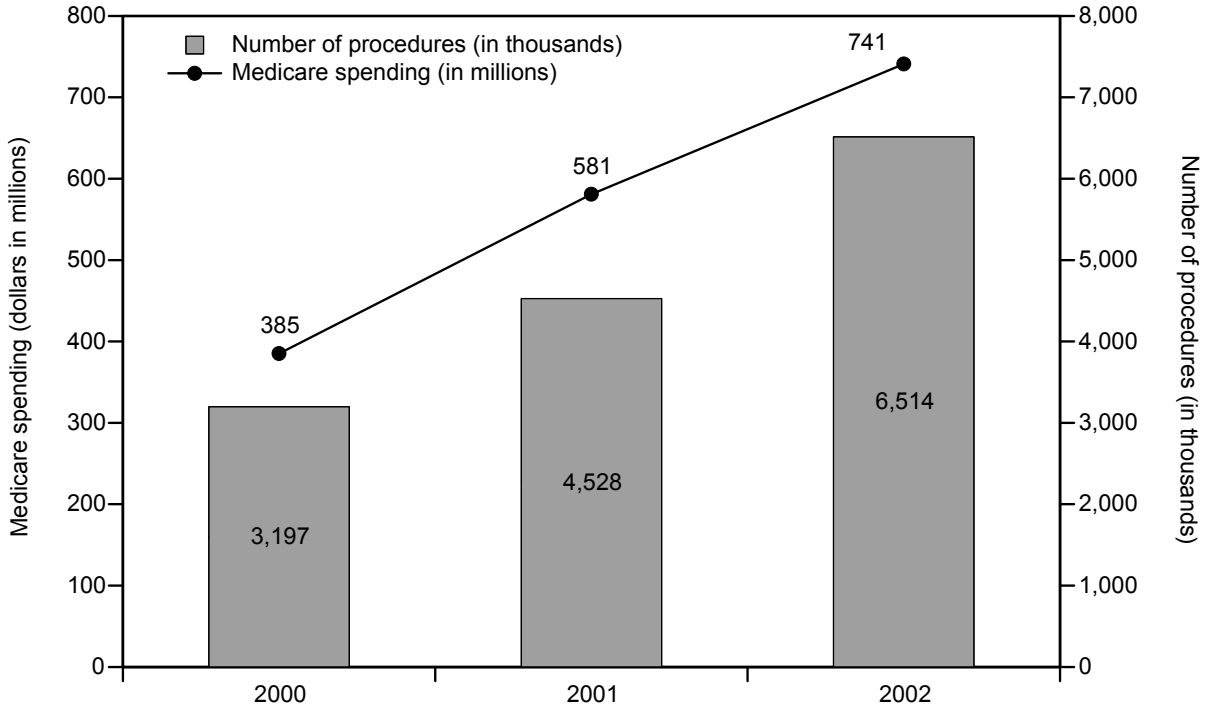
Source: MedPAC analysis of 5 percent Standard Analytic File of independent diagnostic testing facility claims from CMS.

- Independent diagnostic testing facilities (IDTFs) are independent of a hospital and physician office and only provide outpatient diagnostic services. Medicare also pays for outpatient diagnostic services provided by hospital outpatient departments and physician offices. Medicare pays for IDTF services under the physician fee schedule at the same rates as physician offices.

- Imaging procedures—every category except for tests and other services—account for 85 percent of Medicare spending for IDTF services ($630 million).

- CMS applies specific rules to IDTFs that do not apply to physician offices that provide diagnostic tests. For example, IDTFs must have supervising physicians who oversee testing quality and nonphysician staff who are licensed or certified. However, enforcement of these standards is not rigorous: after initial enrollment in Medicare, IDTFs are generally not subject to periodic survey and certification.

Chart 8-26. Medicare volume and spending for independent diagnostic testing facility services doubled between 2000 and 2002



Note: Medicare spending includes program spending and beneficiary cost sharing.

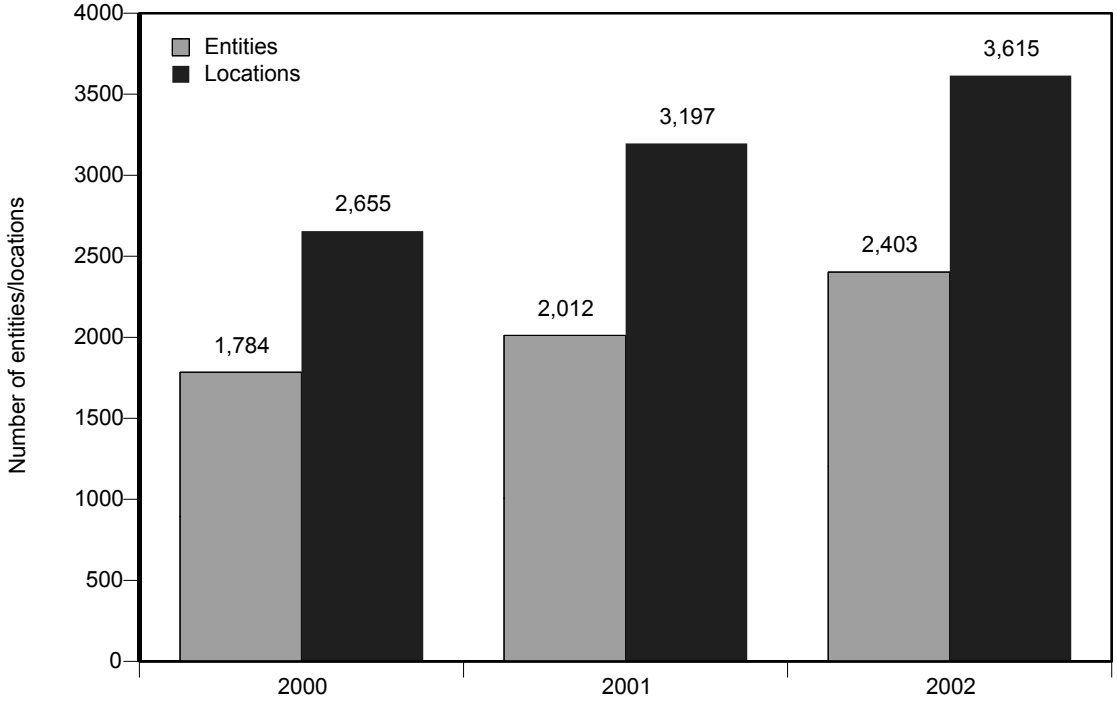
Source: MedPAC analysis of 5 percent Standard Analytic File of independent diagnostic testing facility claims from CMS.

- Medicare spending for independent diagnostic testing facility (IDTF) services nearly doubled between 2000 and 2002, from $385 million to $741 million. Most IDTF services are imaging procedures. Medicare spending for all imaging services paid under the physician fee schedule grew at half that rate—27 percent—during the same period.

- The categories of IDTF services that experienced the fastest spending growth were: cardiac catheterization and related imaging procedures (271 percent), computed tomography (164 percent), and nuclear medicine (121 percent).

- Total Medicare spending (program spending and beneficiary cost sharing) for imaging services paid under the physician fee schedule was $8.1 billion in 2002; 8 percent of that amount was provided in IDTFs.

Chart 8-27. The number of independent diagnostic testing facilities grew rapidly between 2000 and 2002



Note: An entity refers to a unique business entity. Each entity may have multiple fixed or mobile locations. On average, each entity had 1.5 locations in 2002.

Source: MedPAC analysis of 5 percent Standard Analytic File of independent diagnostic testing facility claims.

- Using Medicare claims data, we identified 2,400 independent diagnostic testing facility (IDTF) business entities in 2002. Each entity may have more than one (fixed or mobile) location—over 3,600 IDTF locations submitted Medicare claims in 2002.

- Between 2000 and 2002, the number of IDTF entities grew by 16 percent per year, on average, and the number of locations increased by 17 percent per year, on average. By comparison, Medicare spending for IDTF services grew by almost 40 percent per year, on average, during this period.

Web links. Ambulatory care

Physicians

- Chapter 3B of the MedPAC March 2004 Report to the Congress provides additional information on physician services.

  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3B.pdf

- The 2004 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds provides details on historical and projected spending on physician services.

  http://www.cms.hhs.gov/publications/trusteesreport/2004/tr.pdf

- Congressional testimony by the Chairman of MedPAC on May 5, 2004 discusses payment for physician services in the Medicare program.

  http://www.medpac.gov/publications/congressional_testimony/050504_SGRTestimony_EC.pdf

Hospital outpatient services

- Chapter 3A of the MedPAC March 2004 Report to the Congress provides additional information on hospital outpatient services, including outlier and transitional corridor payments.

  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3A.pdf

- A description of coinsurance under the outpatient PPS can be found in Chapter 9 of the MedPAC March 2001 Report to the Congress.

  http://www.medpac.gov/publications/congressional_reports/Mar01%20Ch9.pdf

- More information on new technology and pass-through payments can be found in Chapter 4 of the MedPAC March 2003 Report to the Congress.

  http://www.medpac.gov/publications/congressional_reports/Mar03_Ch4.pdf

Ambulatory surgical centers

- Chapter 3F of the MedPAC March 2004 Report to the Congress provides additional information on ambulatory surgical centers.

  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch3F.pdf